AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G101 A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE O9/16/2011	
NAME OF PROVIDER OR SUPPLIER A. BOILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER	
I DODE N 400 F	
2906 N 400 E	
CDC INC MONTICELLO, IN47960	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETIC CROSS-REFERENCED TO THE APPROPRIATE	N
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) DATE	
W0000	
W0000	
This visit was for a predetermined full	
recertification and state licensure survey.	
Dates of survey: September 12, 13, 14 and 16,	
2011.	
Facility Number: 000639	
Provider Number: 15G101 AIMS Number: 100234030	
AIMS Number: 100234030	
Surveyor: Claudia Ramirez, RN/Public Health	
Nurse Surveyor III/QMRP	
Thurse our veyor in giring	
These federal deficiencies also reflect state	
findings in accordance with 431 IAC 1.1.	
Quality Review completed 9/23/11 by Chris	
Greeney, ICF-ID Surveyor Supervisor and Ruth	
Shackelford, Medical Surveyor III.	
W0104 The governing body must exercise general	
policy, budget, and operating direction over	
the facility.	
m W0104 Tag W 104 As of 10-6-2011 the $ m 10/10/20$	11
process of reimbursement to the	
Based on record review and interview, the consumers for supplies bought	
governing body failed to exercise general direction in a manner to ensure 3 of 3 sample clients (clients with their personal money has been implemented. A target	
We was a way to a second major	
dates in a 12 in its dempite	
hygiene items and medical items. reimbursement has been set. The ISO form which staff was	
Findings include: following is being revised to	
remove statement of the	
1. On 09/14/11 at 10:00 AM a record review for consumer's responsibility o	
client #1 was completed. The financial review purchase personal hygiene	
indicated client #1 had paid for the following: products. To prevent this from	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	IT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G101	(X2) MULTI A. BUILDIN B. WING		00	(X3) DATE: COMPL 09/16/2	ETED
NAME OF F	PROVIDER OR SUPPLIEF		29	906 N 4	DDRESS, CITY, STATE, ZIP CODE 400 E CELLO, IN47960		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	II PRE TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	CTIVE ACTION SHOULD BE COMI	
	barsoap, toothbrush of \$12.03; 06/13/11 and sunscreen) in the amount of \$25.19. On 09/14/11 at 12:1 Qualified Mental R. (QMRP) was conductient #1 paid for he hygiene items and he those items. 2. On 09/14/11 at 1 client #2 was compindicated client #2 to 06/06/11 personal he barsoap, toothbrush of \$12.03; 06/13/11 (sunscreen) in the abaircut in the amount medication in the amount medication in the arrow in the abaircut in the amount of \$24/11 a foot stoof feet don't touch the to eat) in the amount on 09/14/11 at 12:1 Qualified Mental R. (QMRP) was conductient #2 paid for he hygiene items and for reimbursed for those 3. On 09/14/11 at 12:1	5 PM an interview with the etardation Professional acted. The QMRP indicated er own hair cut, personal coot stool and had not been			happening again the Group Supervisor will monitor recei on a weekly basis.		

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CON		(X3) DATE S COMPL	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G101	A. BUIL		00	09/16/2	
		100101	B. WING		DDDEGG CITY GTATE ZID CODE	03/10/2	011
NAME OF P	ROVIDER OR SUPPLIER			2906 N 4	DDRESS, CITY, STATE, ZIP CODE		
CDC INC					CELLO, IN47960		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	o6/06/11 personal hy and barsoap) in the apersonal hygiene ite of \$5.35; 06/17/11 a \$15.00; 08/15/11 personal hygiene, barbara in the amount of \$17 the amount of \$14.00 On 09/14/11 at 12:11 Qualified Mental Research (QMRP) was conductient #3 paid for he	ad paid for the following: giene items (denture cleaner amount of \$5.30; 06/13/11 ms (sunscreen) in the amount a haircut in the amount of rsonal hygiene items h, bathpuff and two ice packs) 7.72 and 08/20/11 a haircut in 0. 5 PM an interview with the tardation Professional cted. The QMRP indicated r own hair cut and personal ad not been reimbursed for					
W0149	written policies and mistreatment, negle Based on record facility neglected facility's policy a abuse and neglected protect 1 of 6 click home (client #2)	evelop and implement d procedures that prohibit lect or abuse of the client. review, and interview the to implement the nd procedure related to t. The facility neglected ents living in the group and failed to supervise 's aggressive behavior	Wo	0149	Tag W 149 Client #2's Behavior Support has been updated, staff will be trained on the guardian and he approved plan on or before 10-21-2011. Client #2's Behavior Support has been updated, staff will be trained on the guardian and he approved plan on or before	e HRC Plan ee	10/10/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		15G101	B. WING		-	09/16/2	011
			-		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	£		2906 N	400 E		
CDC INC				L	CELLO, IN47960		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)	+	TAG			DATE
while attending the agency's day service					10-21-2011. Day Service staff will be retra	ained	
	1	elected to document			on being proactive during	anica	
		ive action for the			transition period to ensure all	I	
	incidents.				consumers are being safe.		
	Findings include: On 09/12/11 at 2:15 PM and on 09/13/11				Training to be completed on 10-21-2011. Day Service Coordinator has had a meeti with Day Service staff to add	ng	
					staff (Day Service) to staff (G		
	at 10:57 AM, the	e facility's BDDS Reports			Home) socialization during		
	were reviewed from 10/06/10 through 03/22/11 and indicated the following:				transition period.	ata a at	
					Day Service staff will be retra on being proactive during	ained	
		_			transition period to ensure all	ı	
	1. A BDDS Ren	ort, dated 03/17/11, for			consumers are being safe.		
	1	3/17/11 at 9:10 AM			Training to be completed on	or by	
		had asked/offered [client			10-21-2011. Day Service		
	1	ities; [client #2] refused	Coordinator has had a meeting				
	I -				with Day Service staff to add staff (Day Service) to staff (G		
	1 -	was in an activity that			Home) socialization during	Joup	
	1 "	efused participation.			transition period.		
	1	ed up a beanbag, threw it			For consumer to consumer		
	1 - 1	he beanbag hit [client #1]			aggression the "Team" will re		
	on the left arm.	[Client #1] was not			incidents and recommend ful		
	injured and [clie	nt #1] continued activity.			corrective actions to be taker		
	Staff initiated [c]	lient #2's] Behavior			Implementing of any corrective		
	1	SP); asked [client #2] to			action will be the Department Coordinator's responsibility.	ι	
		[Client #2] refused.			Monitoring of the corrective		
		escorted (per BSP) to			actions will be done by		
		seconds. Staff was			Department Coordinator as		
	1 -				needed		
	attempting to keep [client #2] in active treatment and [client #2] continued to refused (sic) activities. [Client #2] was separated from other consumers throughout the day to ensure safety.				For consumer to consumer		
					aggression the "Team" will re incidents and recommend fur		
					corrective actions to be taker		
					Implementing of any corrective		
					action will be the Departmen		
	1	rically reacts with			Coordinator's responsibility.		
	inappropriate be	haviors when			Monitoring of the corrective		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLE	TED
		15G101	B. WIN		-	09/16/20	11
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	-		2906 N			
CDC INC	<u> </u>			1	CELLO, IN47960		
		TATEL VENT OF DEPLOYENCIES				-	(775)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CV MUST BE REDGEDED BY ELLL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE
IAG	 	<u> </u>	+	IAG	actions will be done by	+	DATE
	expectations are	set by staff."			Department Coordinator as		
					needed		
	2. A BDDS Rep	ort, dated 04/14/11, for		For consumer to consumer			
	an incident on 04/13/11 at 4:00 PM				aggression the "Team" will re	eview	
	indicated, "[Clien	nt #2] got up from chair			incidents and recommend fu		
		[client #1], who was			corrective actions to be taken		
	l ` ′	and [client #2] pulled			Implementing of any correcti		
		Staff followed [client			action will be the Departmen	t	
					Coordinator's responsibility. Monitoring of the corrective		
	#2's] behavior plan. Redirected staff on being proactive, including at the end of the day as this is when this behavior				actions will be done by		
					Department Coordinator as		
					needed		
	began. Staff will keep [client #2] and						
	[client #1] at arm	ns length AS MUCH AS					
	POSSIBLE. Enc	courage [client #2] to					
	shake hands whe	n departing."					
	3 A BDDS Ren	ort, dated 05/03/11, for					
	1	5/02/11 at 4:00 PM					
		p home staff arrived at					
	· ·	•					
	1 *	pick consumer up.					
	1 ^	vas handing a bag to the					
	1 ~ ^	F; [client #2] reached over					
	1 -	ent #1's] hair. [Client #1]					
	did not react and	appeared fine. [Client					
	#2] went to quiet	time. It is historical for					
	[client #2] to hav	re issues when					
	transitioning. Sta	aff was instructed to					
		imers are at least an arms					
		n each other at all times."					
	1311gui away 11011	. cach onioi at all tillios.					
	A A RDDC Dan	ort dated 07/15/11 for					
	4. A BDDS Report, dated 07/15/11, for an incident on 07/15/11 at 10:05 AM						
		e transitioning, [client #2]					
	grabbed [dayserv	vice client #3] and					

l	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G101	(X2) MULTIPLE CC A. BUILDING B. WING	00	COM	TE SURVEY IPLETED 5/2011
NAME OF I	PROVIDER OR SUPPLIER		2906 N	ADDRESS, CITY, STATE, ZIP 400 E CELLO, IN47960	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
	bruise at this tim the past that [clie well to transition cause this behav behavior plan an quiet time. Staff inappropriatenes #2] and [dayserv an arms length a 5. A BDDS Rep an incident on 04 indicated, "[Clie workshop classre #2] was reading [Client #4] bump #2's] wheelchair after incident). [reacted by yellin #4] retaliate by p client #2] in the blade. [Client #4 away from [days that her hand hum [dayservice client was crying. Staff client #4 calmed [client #4] the in actions. Staff dis how to appropria	ving a red mark but no e. It has been noted in ent #2] does not respond ing which potentially iorStaff followed d placed [client #2] into informed [client #2] the s of her actions. [Client ice client 3] remained at way from each other." ort, dated 04/14/11, for 4/14/11 at 2:25 PM int #4] was walking in the boom. [Dayservice client a book at the bookshelf. bed into [dayservice client (stated by [client #4] Dayservice client #2] g at [client #4]. [Client bunching [dayservice right upper back shoulder d] immediately walked ervice client #2] stating it that she used to hit it #2] with. [Client #4] If checked [dayservice ury; none notice at that d with [client #4] and d. Staff discussed with appropriateness of her scussed with [client #4] itely request someone to list to get through. [Client				

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL	
AND PLAN	OF CORRECTION	15G101	A. BUII	LDING	00	09/16/2	
		136101	B. WIN			09/10/2	011
NAME OF	PROVIDER OR SUPPLIE	R		2906 N	ADDRESS, CITY, STATE, ZIP CODE		
CDC INC				1	CELLO, IN47960		
(X4) ID		STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	· ·	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	DATE
	#4] stated that sl	he was sorry. [Client #4]					
	was checked for	injuries in her right hand;					
	none were noticed. Staff reviewed with						
	[client #4] the co	onsequences of causing					
	pain to others ar	nd herself when physically					
	aggressive."						
	6. A BDDS Report, dated 08/25/11, for						
	an incident on 08/24/11 at 3:00 PM						
	indicated, "[Client #4] was walking						
	towards the lockers. [Dayservice client						
	#4] was also standing by the lockers.						
	[Client #4] made	e an advance towards					
	[dayservice clien	nt #4] as if [client #4] was					
	going to "choke"	" [dayservice client #4].					
	[Client #4] did r	not actually make neck					
	contact with [da	yservice client #4].					
	[Dayservice clie	ent #4] then hit [client #4]					
	with a closed fis	t on her nose. [Client #4]					
	began to cry and	I stated "he hurt my nose."					
	[Client #4] has a	also had another					
	behavioral issue	towards [dayservice					
	client #4] recent	ly as well. Day Service					
	1	service client #4] more					
	1	defending himself and					
	could have felt t	hreatenedIt is					
		nat [client #4] and					
	1	nt #4] stay out of arms					
		n other to prevent further					
	issues."						
		port, dated 08/30/11, for					
		8/29/11 at 4:10 PM					
	indicated, "Cons	sumer's (sic) had come					

PRINTED: 10/13/2011 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G101	(X2) MULT A. BUILDIN B. WING		00	(X3) DATE S COMPL 09/16/2	ETED
NAME OF I	PROVIDER OR SUPPLIER		2	906 N 4	DDRESS, CITY, STATE, ZIP CODE 400 E CELLO, IN47960	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	out their lunchbod [client #2] and [cdining room tabl Staff followed [cww2] had a 1 1/2" purple in color of [Client #4's] psychotropic meadjusted. At the have not had a repsychiatrist." On 09/12/11 at 3 facility's "Policy dated 02/22/11 in name]'s policy prexploitation, mistiviolation" On 09/14/11 at 1 with the Qualified Professional (QMThe QMRP indicated to follow to protect clients further indicated behaviors. She fagency did not defining the color of the professional (QMThe QMRP indicated behaviors. She fagency did not defining the color of the professional (QMThe QMRP indicated behaviors. She fagency did not defining the color of the professional (QMThe QMRP indicated behaviors. She fagency did not defining the color of the professional (QMThe QMRP indicated behaviors. She fagency did not defining the color of the professional (QMThe QMRP indicated behaviors).	2:15 PM an interview of the agency of the ag					

000639

PRINTED: 10/13/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING B. WING	LE CONSTRUCTION 00	(X3) DATE COMP 09/16/	LETED	
NAME OF F	PROVIDER OR SUPPLIER		STR 290	EET ADDRESS, CITY, STATE, ZIP 06 N 400 E 0NTICELLO, IN47960	- CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETION DATE
W0157	Based on record rev BDDS (Bureau of D Services) reports reg facility failed to initic corrective action to abuse to client #1 by and #4 and to prever consumers/clients at Findings include: On 09/12/11 at 2:15 AM, the facility's BI	tion is verified, appropriate nust be taken. iew, and interview for 7 of 7 revelopmental Disability garding client aggression, the iate and document immediate prevent incidents of client of failing to supervise clients #2 nt physical aggression to the agency's workshop. PM and on 09/13/11 at 10:57 DDS Reports were reviewed gh 03/22/11 and indicated the	W0157	Tag W 157 Client #2's Behavio has been updated, trained on the guard approved plan on o 10-21-2011. Trainin going. Client #2's Behavio has been updated, trained on the guard approved plan on o 10-21-2011. Day Service staff w on being proactive of transition period to consumers are bein	staff will be dian and HRC r before g will be on r Support Plan staff will be dian and HRC r before ill be retrained during ensure all	10/10/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

DDS411

000639

Facility ID:

If continuation sheet

Page 9 of 23

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
		15G101	B. WIN			09/16/2	011
		1	B. WII.		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	R		2906 N			
CDC INC				1	CELLO, IN47960		
CDC INC	,			INICIATIO	CELLO, 11147900		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
	following:				Training to be completed on	or by	
					10-21-2011. Day Service	•	
	1. A BDDS Report	, dated 03/17/11, for an			Coordinator has had a meeti	ng	
		1 at 9:10 AM indicated, "Staff			with Day Service staff to add	ress	
		client #2] several activities;			staff (Day Service) to staff (C	Group	
		all. [Client #1] was in an			Home) socialization during		
		#2] had refused participation.			transition period.		
	[Client #2] picked up a beanbag, threw it at [client				Day Service staff will be retra	ained	
	1 2 4				on being proactive during		
	#1]. The beanbag hit [client #1] on the left arm. [Client #1] was not injured and [client #1]				transition period to ensure al	l	
	[Client #1] was not injured and [client #1] continued activity. Staff initiated [client #2's]				consumers are being safe.		
	Behavior Support Plan (BSP); asked [client #2] to				Training to be completed on	or by	
	go to quiet area. [Client #2] refused. [Client #2]				10-21-2011. Day Service		
	was escorted (per BSP) to quiet time for 60				Coordinator has had a meeti	•	
	seconds. Staff was attempting to keep [client #2]				with Day Service staff to add		
		and [client #2] continued to			staff (Day Service) to staff (G	Froup	
		ies. [Client #2] was separated			Home) socialization during		
	1 1	ers throughout the day to ensure			transition period.		
		historically reacts with			. For consumer to consumer		
		viors when expectations are set			aggression the "Team" will re		
		d of documented effective			incidents and recommend fu		
	l -	as available for review.			corrective actions to be taken		
	corrective action wa	as available for fevicw.			Implementing of any correcti		
	2 A RDDS Report	, dated 04/14/11, for an			action will be the Departmen	τ	
		1 at 4:00 PM indicated,			Coordinator's responsibility.		
		from chair (sic) and went to			Monitoring of the corrective		
		s sitting in a chair, and [client			actions will be done by		
		1's] hair. Staff followed [client			Department Coordinator as needed.		
		Redirected staff on being			Immediate increase of staff v	vill	
		g at the end of the day as this is			be put in place until the "Tea		
	1 *	began. Staff will keep [client			meets and determines the n		
		at arms length AS MUCH AS			steps to ensure the safety of		
		rage [client #2] to shake hands			consumers from consumer to		
		No record of documented			consumer aggression. For	-	
		action was available for			consumer to consumer		
	review.	action was available 101			aggression the "Team" will re	eview	
	10 VICW.				incidents and recommend fu		
	3 A RDDS Report	, dated 05/03/11, for an			corrective actions to be take		
		1 at 4:00 PM indicated, "Group			Implementing of any correcti		
		at the workshop to pick			action will be the Departmen		
	nome stan annveu a	it the workshop to pick			Coordinator's responsibility.		

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPI	LETED
		15G101	B. WIN			09/16/2	011
		l .	D. WI		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8		2906 N			
CDC INC	?			1	CELLO, IN47960		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	_	sshop staff was handing a bag			Monitoring of the corrective		
		staff; [client #2] reached over			actions will be done by		
	and grabbed [client #1's] hair. [Client #1] did not react and appeared fine. [Client #2] went to quiet time. It is historical for [client #2] to have issues when transitioning. Staff was instructed to ensure that consumers are at least an arms length away from each other at all times." No record of				Department Coordinator as needed.		
					Immediate increase of staff v	will	
					be put in place until the "Tea		
					meets and determines the n		
					steps to ensure the safety of		
		ve corrective action was			consumers from consumer to		
	available for review				consumer aggression. For		
	a variable for review	•			consumer to consumer		
	4. A BDDS Report, dated 07/15/11, for an incident on 07/15/11 at 10:05 AM indicated,				aggression the "Team" will re		
					incidents and recommend fu		
	"While transitioning, [client #2] grabbed				corrective actions to be taken		
		3] and pinched him, leaving a			Implementing of any correcti		
	red mark but no bru	ise at this time. It has been			action will be the Departmen	τ	
	noted in the past that	at [client #2] does not respond			Coordinator's responsibility. Monitoring of the corrective		
	well to transitioning	g which potentially cause this			actions will be done by		
	behaviorStaff foll	owed behavior plan and placed			Department Coordinator as		
		et time. Staff informed [client			needed. Training will be on g	ioing.	
		teness of her actions. [Client				, 0	
		client 3] remained at an arms					
		ach other." No record of					
		ve corrective action was					
	available for review	<i>'</i> .					
	5 A DDDG B						
		, dated 04/14/11, for an 1 at 2:25 PM indicated,					
		alking in the workshop					
		rvice client #2] was reading a					
		elf. [Client #4] bumped into					
		2's] wheelchair (stated by					
		ident). [Dayservice client #2]					
		t [client #4]. [Client #4]					
		ig [dayservice client #2] in the					
		oulder blade. [Client #4]					
		d away from [dayservice client					
		hand hurt that she used to hit					
	[dayservice client #2] with. [Client #4] was						
		ed [dayservice client #2] for					

000639

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S COMPL	
AND PLAN	OF CORRECTION	15G101	A. BUI	LDING	00	09/16/2	
		130101	B. WIN			03/10/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CDC INC				2906 N	400 E CELLO, IN47960		
				MONT	CELLO, 11147900		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCI)		DATE
		at that timeStaff talked with that #4 calmed. Staff discussed					
		nappropriateness of her					
		ssed with [client #4] how to					
		at someone to move if she					
		. [Client #4] stated that she					
	was sorry. [Client #	4] was checked for injuries in					
		were noticed. Staff reviewed					
		consequences of causing pain					
		when physically aggressive."					
		ented effective corrective					
	action was available for review. 6. A BDDS Report, dated 08/25/11, for an						
	_	at 3:00 PM indicated,					
	"[Client #4] was wal	lking towards the lockers.					
	[Dayservice client #	4] was also standing by the					
		made an advance towards					
		as if [client #4] was going to					
		client #4]. [Client #4] did not					
		contact with [dayservice client					
		ent #4] then hit [client #4] her nose. [Client #4] began to					
		art my nose." [Client #4] has					
	· ·	avioral issue towards					
		recently as well. Day					
		dayservice client #4] more					
	· ·	nding himself and could have					
		recommended that [client #4]					
		nt #4] stay out of arms length					
		revent further issues." No					
		ed effective corrective action					
	was available for rev	/ICW.					
	7. A BDDS Report	, dated 08/30/11, for an					
	_	at 4:10 PM indicated,					
		nd come home from workshop					
		ut their lunchboxes. [Client					
		2] and [client #2] hit corner of					
	dining room table ar	nd fell to the floor. Staff					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G101		(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE S COMPLI 09/16/20	ETED	
NAME OF F	PROVIDER OR SUPPLIER		STREET A 2906 N	ADDRESS, CITY, STATE, ZIP CODE 400 E CELLO, IN47960		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE	E	(X5) COMPLETION
TAG	followed [client #4's 1/2" straight long br buttock cheek[Clie called to determine her psychotropic me At the time of this response from the prodocumented effective available for review On 09/14/11 at 12:1 Qualified Mental Re (QMRP) was condu	5 PM an interview with the etardation Professional cted. The QMRP indicated the ument effective corrective	TAG	DEFICIENCY)		DATE
W0249	formulated a client each client must retreatment program interventions and sumber and frequence achievement of the individual program. Based on observation interview, the facility clients (clients #1 ar	erdisciplinary team has I's individual program plan, eceive a continuous active in consisting of needed services in sufficient ency to support the ency to support the ency to support the in plan. In, record review, and by failed for 2 of 3 sampled and #2) who had a dining the objective was implemented	W0249	Tag W 249 All Staff will be retrained on the implemen of the objectives inthe Indi Support Plan on or before 10-21-2011. To ensure all	vidual	10/10/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		· ·	(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED 09/16/2011	
		15G101	B. WING		09/16/2011	
NAME OF F	PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE	-	
			2906 N			
CDC INC	,		MONTI	CELLO, IN47960		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	per the Individualize	ed Support Plan (ISP).		are following the Individual		
	E' 1' ' 1 1			Support Plans the Group Ho		
	Findings include:			Supervisor will monitor staff least weekly to ensure on go	I	
	1 On 09/12/11 from	n 4:40 PM until 6:15 PM		training and completion of th		
		group home were completed.		objectives are being done.		
	_	PM, client #5 was observed to				
		around the dining room table				
		3, #4 and #5. Client #1 was				
		rompted or assisted to place				
	her plate on the table	e.				
	Client #1's records v	vere reviewed on 09/13/11 at				
		1's ISP dated 06/28/11				
	indicated client #1 h	ad a goal to place her plate on				
	the dinner table.					
		5 PM an interview with the				
	*	etardation Professional cted. The QMRP indicated				
		e been prompted and assisted				
	by staff to follow he					
		-				
		n 4:40 PM until 6:15 PM				
	_	group home were completed.				
		PM, client #5 was observed to				
		around the dining room table 3, #4 and #5. Client #2 was				
		prompted or assisted to place				
	her plate on the table	-				
	_					
		vere reviewed on 09/13/11 at				
		s ISP dated 06/16/11 indicated				
	client #2 had a goal	to place her plate on the table.				
	On 09/14/11 at 12·1	5 PM and interview with the				
		etardation Professional				
	•	cted. The QMRP indicated				
	client #2 should hav	e been prompted and assisted				
	by staff to follow he	r objective.				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		COMPLETE		(X3) DATE SURVEY COMPLETED	
		15G101	A. BUILDING B. WING		09/16/2011
NAME OF PROVIDER OR SUPPLIER CDC INC			STREET A 2906 N	ADDRESS, CITY, STATE, ZIP CODE 400 E CELLO, IN47960	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
W0263	programs are condinformed consent of client is a minor) of the sampled clients (client grograms for psychologialed to obtain writted client #1's guardianted Behavior Support Plandings include: Client #1's records with 12:10 PM. Client #1 indicated client #1 indicated client #1 indicated client #1 indicated to the addition of behavior) PRN (as in by the guardian on the sample of the sample o	iew and interview, for 1 of 3 ent #1) who had restrictive obtropic medication, the facility ten informed consent from prior to implementing the lan (BSP). In the lan (BSP). In the lan (BSP) was dated the lan (BSP) was dated the lan (BSP) was signed lated it was updated on that date of Haldol (to treat psychotic lated). The BSP was signed lan Rights Committee) meeting lan Rights Committee) meeting lan Rights Committee) meeting land land land land land land land land	W0263	Tag W 263 QDDP-D will document any and all approvany Behavior Support Plan beguardian prior to HRC approcopy of documentation will be placed in the agency's HRC and the original of the documentation will be placed the consumer's Master files the signed copy of the Behave Support Plan.	oy val. A e book d in with

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G101	B. WING		09/16/2011
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
CDC INC			2906 N	400 E CELLO, IN47960	
				CELLO, 11147900	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
IAG	1.1-3-4(a)	LSC IDENTIFYING INFORMATION)	IAG	BEI ICIENCI)	DATE
	1.1-3-4(a)				
W0268	-	d procedures must promote pment and independence	W0268	Tag W 268As of 10-21-2011	all 10/10/2011
	interview for 3 of 3 and #3) and for 2 ad #5) who lived in the		W 0200	age inappropriate items will be removed from both the Day Service Program and the Ground Home. To ensure such items have been removed a visual check of the area will be don a monthly basis by Day Serv Coordinator or designee and	e on ice
	Findings include:			Group Home Supervisor or designee.	
		conducted at the facility on the times which included the ons:			
	During the observation time on 09/12/11 from 4:40 PM until 6:15 PM the group home activities included a game, "Hands Down" which was listed for ages 6+. The shelves contained books which included, "Peek-a-boo," "I Spy a Puppy," "Keep Kids Safe" and "Snow White." Observations on 09/13/11 from 10:00 AM until 11:00 AM at the agency dayservice program included the following activities in the room: children puzzles, children color books, crayons, and children books.				
	Qualified Mental Re (QMRP) was condu- staff should ensure t ensure the clients us She indicated the cli	5 PM an interview with the stardation Professional cted. The QMRP indicated he dignity of the clients and ed age appropriate materials. ents were not children and not dignified for adults.			

STATEMENT OF DEFICIENCIES X1) PROVI		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RUH DING 00		COMPLETED	
		15G101	A. BUILDING B. WING		09/16/2011	
				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	L.				
CDC INC			2906 N			
CDC INC	,		IMONTI	CELLO, IN47960		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	1.1-3-5(a)					
W0289	The use of system	natic interventions to				
***0207		riate client behavior must be				
		he client's individual				
	•	ccordance with §483.440(c)				
	(4) and (5) of this					
		·	W0289	Tag W 289	10/11/2011	
	Based on observation	on, interview, and record	1,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Client #2's Behavior Suppor		
		failed to include the utilization		has been updated, staff will	be	
		ent #2) of keeping client #2 "at		trained on the guardian and	HRC	
	· ·	er clients, (due to client's		approved plan on or before		
	_	physical aggression: i.e.		10-21-2011.		
		apping, or other physical		Client #2's Behavior Suppor	t Plan	
		vards another person with the		has been updated, staff will		
		rm), as a part of the client's		trained on the guardian and	HRC	
	treatment plans.	ini), as a part of the chefit's		approved plan on or before		
	treatment plans.			10-21-2011.		
	Findings include:			Day Service staff will be retr	ained	
	- manago morado.			on being proactive during		
	On 09/12/11 from 4	:40 PM until 6:15 PM		transition period to ensure a	"	
		onducted in the group home.		consumers are being safe.	or by	
		ved to walk through the home		Training to be completed on 10-21-2011. Day Service	OI DY	
		rough rooms with other clients		Coordinator has had a meet	ing	
		close proximity (less than an		with Day Service staff to add	· ' '	
		o clients #1, #3, #4 and #5		staff (Day Service) to staff (
		nome. At 5:40 PM client #4		Home) socialization during	J. 0 0 P	
		te, "Ouch, [client #2] pinched		transition period.		
	me."	· · · · · · · -] k		Day Service staff will be retr	ained	
				on being proactive during		
	On 09/12/11 at 2:15	PM and on 09/13/11 at 10:57		transition period to ensure a	.II	
		DDS Reports were reviewed		consumers are being safe.		
		igh 03/22/11 and indicated the		Training to be completed on	or by	
	following for client	•		10-21-2011. Day Service	´	
	is in a circuit	·· ·		Coordinator has had a meet	ing	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G101		A. BUILI	DING	NSTRUCTION 00	(X3) DATE SU COMPLE 09/16/20	TED	
CDC INC	PROVIDER OR SUPPLIER		B. WING	2906 N	DDRESS, CITY, STATE, ZIP CODE 400 E CELLO, IN47960		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
	incident on 03/17/11 had asked/offered [c [client #2] refused a activity that [client # [Client #2] picked u #1]. The beanbag h [Client #1] was not continued activity. Behavior Support Pl go to quiet area. [Cl was escorted (per B seconds. Staff was a in active treatment a refused (sic) activiti from other consume safety. [Client #2] hinappropriate behav by staff." 2. A BDDS Report, incident on 04/13/11 "[Client #2] got up f [client #1], who was #2] pulled [client #1 #2's] behavior plan. proactive, including when this behavior l #2] and [client #1] a POSSIBLE. Encour when departing." 3. A BDDS Report, incident on 05/02/11 home staff arrived a consumer up. Work to the group home s and grabbed [client #1].	dated 03/17/11, for an at 9:10 AM indicated, "Staff client #2] several activities; II. [Client #1] was in an #2] had refused participation. p a beanbag, threw it at [client it [client #1] on the left arm. injured and [client #1] Staff initiated [client #2's] an (BSP); asked [client #2] to itent #2] refused. [Client #2] sP) to quiet time for 60 attempting to keep [client #2] and [client #2] was separated rs throughout the day to ensure historically reacts with iters when expectations are set dated 04/14/11, for an at 4:00 PM indicated, from chair (sic) and went to estitting in a chair, and [client red) hair. Staff followed [client Redirected staff on being at the end of the day as this is began. Staff will keep [client at arms length AS MUCH AS rage [client #2] to shake hands dated 05/03/11, for an at 4:00 PM indicated, "Group the workshop to pick shop staff was handing a bag taff; [client #2] reached over #1's] hair. [Client #1] did not fine. [Client #2] went to quiet			with Day Service staff to add staff (Day Service) to staff (Ohme) socialization during transition period. For consumer to consumer aggression the "Team" will reincidents andrecommend fur corrective actions to be taken Implementing of any correctivaction will be the DepartmentCoordinator's responsibility. Monitoring of tocorrective actions will be don Department Coordinator as needed For consumer to consumer aggression the "Team" will reincidents andrecommend fur corrective actions to be taken Implementing of any correctivaction will be the DepartmentCoordinator's responsibility. Monitoring of tocorrective actions will be don Department Coordinator as needed For consumer to consumer aggression the "Team" will reincidents andrecommend fur corrective actions to be taken Implementing of any correctivaction will be the DepartmentCoordinator's responsibility. Monitoring of tocorrective actions to be taken Implementing of any correctivaction will be the DepartmentCoordinator's responsibility. Monitoring of tocorrective actions will be don Department Coordinator as needed	eview ther n. ve he heby eview ther n. ve	

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G101	A. BUILD		NSTRUCTION 00	(X3) DATE COMPI 09/16/2	LETED
NAME OF F	PROVIDER OR SUPPLIER			2906 N	DDRESS, CITY, STATE, ZIP CODE 400 E CELLO, IN47960		
	SUMMARY S (EACH DEFICIEN REGULATORY OR time. It is historical when transitioning. that consumers are a from each other at a 4. A BDDS Report, incident on 07/15/1: "While transitioning [dayservice client #; red mark but no bru noted in the past tha well to transitioning behaviorStaff folle [client #2] into quie #2] the inappropriat #2] and [dayservice length away from ea Client #2's records v 1:06 PM. Client #2 (BSP) annual update client #2 had targete "physical aggression slapping, or other pl towards another per harm). The BSP inc aware at all times w other individuals in The Qualified Ment (QMRP) was intervented.	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) for [client #2] to have issues Staff was instructed to ensure at least an arms length away Ill times." dated 07/15/11, for an I at 10:05 AM indicated, g, [client #2] grabbed 3] and pinched him, leaving a ise at this time. It has been at [client #2] does not respond a which potentially cause this bowed behavior plan and placed at time. Staff informed [client eness of her actions. [Client client 3] remained at an arms anch other." were reviewed on 09/13/11 at as Behavior Support Plan ed 06/14/11 plan indicated and behaviors including, anche i.e. pinching, hitting, anysical contact directed son with the intent of causing dicated, "staff need to be there [client #2] is in relation to		2906 N	400 E	Е	(X5) COMPLETION DATE
		be an arm's length away from BSP did not accurately reflect					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G101		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/16/2011	
NAME OF PROVIDER OR SUPPLIER CDC INC			2906 N	ADDRESS, CITY, STATE, ZIP CODE 400 E CELLO, IN47960	
CDC INC (X4) ID PREFIX TAG	The facility must k biologicals locked prepared for admining a PRN (as needed) repared for agency day service. On 09/13/11 from 6 09/13/11 from 10:00 observations were conducted and the agency day at 7:50 AM staff #1 containing medication.	except when being nistration. n and interview, the facility roper medication security for 1) whose medications included nedication which was sent to	I		all 10/11/2011 to to the clock e all cis a finted k box home one es rawer
	#1 and contained the The three ring binde was on the kitchen of An interview was contained and the transport. On 09/13/11 at 10:1	e medication Haldol 1 mg. er was placed in a bag which		keep meds locked in it at all times. Monitoring will be don Day Service staff designated daily basis. To ensure meds kept locked.	l on a

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE S COMPLI	
		15G101	A. BUIL B. WING			09/16/20	011
NAME OF F	PROVIDER OR SUPPLIER			2906 N 4	DDRESS, CITY, STATE, ZIP CODE 400 E ELLO, IN47960		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	┰	ID	NO CAMPAGNA NA LAY OF GOND TOTAL		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	1	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)	_	DATE
	of Haldol (to treat primedication was not accessible to anyone. The binder was left clients when staff at were not at the table dayservice staff #1 v 10:15 AM and she in the dayservice sent to in the binder. She in on the table during to indicated the medicinated the medicinated when the company of the co	ed client #1's medication card sychotic disorders). The locked. The binder was a who walked into the room. Unattended on the table with tended to other clients who a. An interview with was conducted on 09/13/11 at indicated the group home and the medication back and forth indicated the binder was kept he dayservice hours. She in was not locked at the day stardation Professional ceted. The QMRP indicated all be locked when unattended by the medication should have sport and at the dayservice					
	1.1-3-6(a)						
W0488	_	ssure that each client eats stent with his or her el.	W)488	Tag W488 Staff will be traine	d on	10/11/2011
	interview, the factorial sampled clients (ation, record review and cility failed for 3 of 3 client #1, #2 and #3) by client prepared their food as possible.			orby 10-21-2011 on ensuring the consumers are preparing serving ther own food correct and per their choices. Monito that the consumers are prepared and serving their own food with done by Group Home Supervision.	that and ly ring aring ill be	10,11,2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

DDS411 Facility ID:

ID: 000639

If continuation sheet

Page 21 of 23

PRINTED: 10/13/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G101	B. WIN			09/16/2	011
NAME OF I	PROVIDER OR SUPPLIEI	3		1	ADDRESS, CITY, STATE, ZIP CODE		
ODO INC				2906 N			
CDC INC				MONTI	CELLO, IN47960		
(X4) ID		STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR	LESC IDENTIFYING INFORMATION)		TAG	or designee on a daily basis	hv	DATE
	Eindings in aluds				visual checks	Dy	
	Findings include	·					
	Observations we	ere conducted in the group					
		11 from 4:40 PM until					
		1 09/13/11 from 6:40 AM					
ļ		At 5:45 PM staff #2 was					
		e baked potatoes on the					
	1	#1, #2 and #3, take the					
	l ^	toes and cut up all of the					
	1	\$2 was observed to cut up					
	l ^	nts #1, #2 and #3. Staff					
		I to pour milk for clients					
		On 09/13/11 at 6:45 AM					
	· ·						
		erved to cut up waffles					
	and nam on cites	nts #1, #2 and #3's plates.					
	Client #1's recor	ds were reviewed on					
		0 PM. Client #1's					
		Functional Assessment					
		28/11 indicated client #1					
	` ′	sistance to pour and to					
	cut up food.	sistance to pour and to					
	- Cat up 100a.						
	Client #2's recor	ds were reviewed on					
		PM. Client #2's					
		Functional Assessment					
	1 ^	16/11 indicated client #2					
	l ` ′	sistance to pour and to					
	cut up food.	F 					
	Client #3's recor	ds were reviewed on					
	09/13/11 at 2:18	PM. Client #3's					
		Functional Assessment					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

DDS411 Facility ID:

000639 If continuation sheet

Page 22 of 23

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G101		(X2) MULTIPLE CC A. BUILDING B. WING	00	COMP 09/16/2	LETED	
NAME OF F	PROVIDER OR SUPPLIER		STREET A 2906 N	ADDRESS, CITY, STATE, ZIP C 400 E CELLO, IN47960	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
TAG	(CFA) dated 02/2 was able with assecut up food. On 09/14/11 at 1 with the QMRP (Retardation Prof The QMRP indicassisted clients #	18/11 indicated client #3 sistance to pour and to 2:15 PM an interview (Qualified Mental ressional) was conducted. Fated staff should have 1, #2 and #3 to prepare and should not have rem.	TAG	DEFICIENCY		DATE